

U.S. Department of Labor

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Date Issued: November 30, 2000

Case Nos: 1998-BLA-467
1998-BLA-468

In the Matter of

RAY HUBBELL, Deceased Miner,
IVA HUBBELL, Widow,

Claimants,

v.

PEABODY COAL COMPANY,

Employer,

and

OLD REPUBLIC INSURANCE CO.,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

Darlene Robinson, Esquire
For the claimant

Dana G. Meier, Esquire
For the employer/carrier

BEFORE: DONALD W. MOSSER
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis.

Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (1996).

Claimants requested a decision on the evidence of record without an oral hearing. As counsel for the employer and for the Director had no objection, the hearing was waived by my order dated December 3, 1999. Accordingly, by that order and subsequent orders, Director's Exhibits (DX) 1 through 37 and 1-A through 18-A, Claimant's Exhibits (CX) 1 through 24, and Employer's Exhibits (EX) 1 through 62 were admitted into evidence. Counsel also submitted a joint stipulation of facts and medical evidence, as well as briefs.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.¹

ISSUES

One of the principal issues involved in the miner's case is whether the denial of Mr. Hubbell's prior claim for benefits should be modified in accordance with Section 725.310(a). However, the following issues are listed on the controversion form (Form CM-1025) and are related to the modification question and Mrs. Hubbell's claim:

1. whether the claim filed by Mr. Hubbell in 1992 should be denied pursuant to Section 725.309(d);
2. whether Mr. Hubbell's claim was timely filed;
3. whether the miner had pneumoconiosis as defined by the Act and regulations;
5. whether his pneumoconiosis arose out of coal mine employment;

¹Section numbers hereinafter cited pertain exclusively to Title 20, Code of Federal Regulations.

6. whether the miner was totally disabled;
 7. whether his total disability was due to pneumoconiosis;
 8. whether the named employers is the responsible operator;
 9. whether Mr. Hubbell's most recent employment of not less than one year was with the named responsible operator; and,
 10. whether the miner's death was due to pneumoconiosis.
- (DX 18, 37).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The miner, Ray Hubbell, was born March 6, 1918, and died on December 17, 1996 at the age of 78. (DX 1, 30). On July 13, 1940, he married Iva C. Horton, with whom he resided in Jasonville, Indiana until his death. (DX 1). He had no other dependents. Mrs. Hubbell has not remarried.

Mr. Hubbell first filed a claim on September 18, 1981. (DX 23). That claim was denied by the district director on December 11, 1981, and no further action was taken by the claimant on that claim. Mr. Hubbell filed his second claim on December 10, 1985. (DX 23). Because it was filed more than one year after the prior denial, it was treated as a duplicate claim pursuant to Section 725.309. It was denied by the district director on April 4, 1985, and again no further action was taken.

Mr. Hubbell filed the current duplicate claim on November 12, 1992. (DX 1). On May 22, 1995, another administrative law judge issued a Decision and Order Awarding Benefits and reaffirmed that award in a Decision and Order on Motion for Reconsideration dated August 25, 1995. (DX 26, 27). That judge found that Mr. Hubbell had established the existence of pneumoconiosis pursuant to Sections 718.202(a)(1) and (4), total disability pursuant to Sections 718.204(c)(1) and (4), and that Mr. Hubbell's total disability was due to pneumoconiosis. The Benefits Review Board (Board) affirmed the administrative law judge's findings in part, vacated them in part, and remanded the case for further consideration under Sections 718.202(a), 718.204(b) and 718.204(c) on December 20, 1996. The Board also required consideration of the material change in condition standard enunciated in *Sahara Coal Co. v. Direc-*

tor, OWCP, 946 F.2d 554 (7th Cir. 1991). (DX 28). The administrative law judge then issued a Decision and Order on Remand - Denying Benefits. (DX 29). He found that the evidence still established pneumoconiosis pursuant to Sections 718.202(a)(1) and (a)(4) and total disability pursuant to Section 718.204(c)(1) and (c)(4), but not that the evidence proved Mr. Hubbell's total disability was due to pneumoconiosis. Mrs. Hubbell requested modification of her deceased husband's claim on October 1, 1997, and the district director denied the request on December 22, 1997. (DX 32, 34). She requested a formal hearing on January 8, 1998. (DX 35). The claim was referred to this office on February 5, 1998. (DX 37).

Mrs. Hubbell filed the survivor's claim involved in this proceeding on March 17, 1997. (DX 1-A). She was found eligible for benefits by the district director on December 8, 1997. (DX 13-A). The employer requested a hearing before an administrative law judge on December 16, 1997. (DX 14). Her claim was also referred to this office on February 5, 1998. (DX 18-A).

Mrs. Hubbell provided an affidavit dated February 28, 2000, stating that Dr. Robert Avena was her husband's primary care physician at the time of death. (CX 24). Dr. Robert Cantillo was another treating physician. In October 1994, Mr. Hubbell was first diagnosed with lung cancer by Dr. Maria B. Antonio-Miranda, who pronounced the disease terminal because the miner's severe breathing problems, in addition to the location of the tumor, ruled out the possibility of surgery. Drs. Aveno and Cantillo agreed with this assessment.

Length of Coal Mine Employment

Mr. Hubbell alleged 42½ years of coal mine employment. (DX 1). The prior administrative law judge credited him with 43 years of coal mine employment based on the parties' stipulation. (DX 26). Based on that stipulation and a review of the record, I also find that Mr. Hubbell was a coal miner for 43 years. I also find that his last job included operating machinery, repairing equipment, shoveling coal, and erecting draglines.

Responsible Operator

Peabody Coal Company was the miner's most recent employer for a cumulative period of at least one year after December 21, 1969 and is the proper responsible operator under Section 725.493. The employer withdrew this issue at the October 25, 1994 hearing, and the record supports the finding that Peabody Coal Company was the most recent coal mine employer. (Tr. 23).

Timeliness

While the employer withdrew the issue of timeliness at the October 25, 1994 hearing, it again appears as an issue in this case. Apparently, the employer contests whether Mr. Hubbell's modification request is timely. However, in *Garcia v. Director, OWCP*, 12 BLR 1-24 (1988), the Benefits Review Board noted the regulatory scheme providing for continuing availability of modification proceedings within one year following any denial by the district director, even after the district director had considered modification once before. The adjudicative actions to be taken by the district director under Section 725.310(c) at the conclusion of the modification proceedings all provide subsequent opportunities to seek modification of that action. See 20 C.F.R. §§ 725.310(c); 725.409(b); 725.418(a), 725.419(d), and 725.421. To achieve the intent of Congress underlying Section 725.310, the parties may request modification of any decision issued by the district director, as the condition of the miner may have changed, since pneumoconiosis is a progressive disease, or a mistake in fact could be discovered. *Stanley v. Betty B Coal Co.*, 13 BLR 1-72 (1990). *Garcia* has been interpreted to permit the filing of an infinite number of modification petitions in a single claim, thereby affording any party the opportunity to continually submit new evidence or arguments to be considered under the less stringent modification standard at Section 725.310 as opposed to that for duplicate claims at Section 725.309. Furthermore, the modification process remains available throughout appellate proceedings.

For these reasons, I find that Mr. Hubbell's current request for modification is both permissible and timely. Accordingly, I will address the merits of Mr. Hubbell's claim.

Pneumoconiosis and Related Issues

I. Medical Evidence

The medical evidence submitted in conjunction with Mr. Hubbell's claims is set forth in the administrative law judges' decisions dated May 22, 1995, August 25, 1995, and July 24, 1997. (DX 26, 27, 29). Following is a summary of the medical evidence submitted since the last denial of Mr. Hubbell's claim and in connection with Mrs. Hubbell's claim.

A. X-rays

| <u>DATE OF X-RAY (REREADING)</u> | <u>EXHIBIT NO.</u> | <u>PHYSICIAN/ QUALIFICATIONS</u> | <u>READING</u> |
|--------------------------------------|--------------------|--------------------------------------|----------------------|
| 1/4/94 | EX 59 | S. Malyala | Changes of emphysema |

| | | | |
|--------------------------------------|--------------------|--------------------------------------|--|
| 1/7/94 | EX 59 | S. Malyala | Emphysema |
| 4/28/94 | DX 4-A | M. Brown | Chronic interstitial fibrotic changes or early interstitial infiltrate |
| 5/7/94 | DX 4-A | B. Wendell | Probably chronic obstructive pulmonary disease with basilar scarring |
| 6/24/94 | DX 4-A | M. Brown | Chronic interstitial changes in both lung bases |
| <u>DATE OF X-RAY (REREADING)</u> | <u>EXHIBIT NO.</u> | <u>PHYSICIAN/ QUALIFICATIONS</u> | <u>READING</u> |
| 6/28/94 | DX 4-A | B. Wendell | No definite active cardiopulmonary process |
| 8/18/94 | DX 4-A | B. Wendell | No acute cardiopulmonary process |
| 10/19/94 | DX 4-A | M. Brown | No significant change in appearance since 8/18/94 |
| 12/26/94 | DX 4-A | W. Mason | Chronic obstructive pulmonary disease with some mild peripheral interstitial fibrotic change |
| 12/31/94 | DX 4-A | B. Wendell | Probable chronic obstructive pulmonary disease |
| 1/8/95 | DX 4-A | B. Wendell | No definite active cardiopulmonary process |
| 3/22/95 | DX 4-A | W. Mason | Minimal interstitial fibrosis |
| 3/24/95 | DX 4-A | W. Mason | Chronic obstructive pulmonary disease with minor interstitial fibrosis |
| 8/6/95 | EX 59 | R. Cantillo | Emphysema |
| 5/5/96 | DX 4-A | B. Wendell | Chronic obstructive pulmonary disease |
| 10/15/96 | EX 58 | B. Wendell | Probably left hilar carcinoma |
| 10/22/96 | EX 59 | Terre Haute Regional Hospital | No pneumothorax is seen; mass lesion in left infrahilar area |

| | | | |
|--|--------------------|--|--|
| 11/5/96 | DX 5-A | S. Malyala | Infrahilar mass lesion on the left side |
| 11/23/96 | DX 5-A | R. Vedala | Fluid in left pleural cavity; malignant neoplasm in left hilar region with atelectatic changes in the lower lobe |
| 11/25/96 | DX 5-A | R. Vedala | Left hilar mass with atelectatic changes in the left lower lobe with fluid in the left pleural cavity |
| <u>DATE OF X-RAY</u> <u>(REREADING)</u> | <u>EXHIBIT NO.</u> | <u>PHYSICIAN/</u> <u>QUALIFICATIONS</u> | <u>READING</u> |
| 11/27/96 | DX 5-A | J. Konijeti | Soft tissue mass in the left hilum with atelectasis of the left lower lobe with some left-sided pleural effusion |

B. Pulmonary Function Studies

| <u>DATE</u> | <u>EXHIBIT</u> | <u>HEIGHT</u> | <u>AGE</u> | <u>FVC</u> | <u>FEV₁</u> | <u>MVV</u> | <u>TRACINGS</u> | <u>EFFORT</u> |
|-------------|----------------|---------------|------------|-------------------------------|------------------------|------------|-----------------|-----------------------|
| 8/18/94 | DX 4-A | 71" | 76 | 1.62 | 1.61 | 47 | Yes | Difficulty initially; |
| | | | | 2.08 | 3.45 | | | some ques- |
| | | | | (Post-bronchodilator results) | | | | tion as to |
| | | | | | | | | his compre- |
| | | | | | | | | hension |

[Dr. Tuteur found this study evinced a mild obstructive ventilatory defect not associated with a restrictive component but associated with air trapping. (EX 60). He found the study invalid as an assessment of maximum function. Dr. Renn found the study invalid for several reasons when he reviewed it on August 3, 1998. (EX 61). He found that there was failure to maintain maximal effort throughout the entire FVC maneuver, resulting in an underestimation of the FEV₁; failure to maintain the prebronchodilator FVC for the requisite six seconds and to plateau for one second, resulting in an underestimation of the FVC; cough during the first second of the FVC maneuver; the lack of three satisfactory FVC maneuvers both before and after bronchodilator; a complete lack of three satisfactory FVC maneuvers; no MVV tracings. Dr. Renn is Board-certified in internal medicine and pulmonary disease.]

C. Arterial Blood Gas Studies

| <u>DATE</u> | <u>EXHIBIT</u> | <u>pCO₂</u> | <u>pO₂</u> | <u>RESTING/</u> |
|-------------|----------------|------------------------|-----------------------|-----------------------|
| | | | <u>(mm.Hg.)</u> | <u>AFTER EXERCISE</u> |
| 1/10/94 | EX 59 | 36 | 54 | Resting |
| 4/28/94 | DX 4-A | 41.7 | 63 | Resting |

| | | | | |
|---------|--------|------|----|---------|
| 5/2/94 | DX 4-A | 40 | 65 | Resting |
| 5/5/94 | EX 54 | 41 | 61 | Resting |
| 5/10/94 | DX 4-A | 40.5 | 51 | Resting |
| 6/24/94 | DX 4-A | 43.6 | 62 | Resting |
| 7/25/94 | DX 4-A | 43.8 | 56 | Resting |
| 8/3/94 | DX 4-A | 37.7 | 66 | Resting |

| <u>DATE</u> | <u>EXHIBIT</u> | <u>pCO2</u> <u>(mm.Hg.)</u> | <u>pO2</u> <u>(mm.Hg.)</u> | <u>RESTING/ AFTER EXERCISE</u> |
|-------------|----------------|--------------------------------|-------------------------------|------------------------------------|
| 10/3/94 | EX 56 | 43 | 69 | Resting |
| 10/17/94 | EX 56 | 46.3 | 63 | Resting |
| 10/22/94 | DX 4-A | 38.2 | 58 | Resting |
| 1/8/95 | DX 4-A | 35 | 51 | Resting |
| 1/13/95 | EX 56 | 47.3 | 63 | Resting |
| 3/26/95 | DX 4-A | 45 | 49 | Resting |
| 5/15/95 | DX 4-A | 37.1 | 70 | Resting |
| 6/21/95 | EX 56 | 55.1 | 52 | Resting |
| 12/4/95 | DX 4-A | 29.6 | 104 | Resting |
| 5/3/96 | EX 54 | 40 | 69 | Resting |
| 5/3/96 | EX 54 | 40 | 70 | Resting |
| 5/3/96 | EX 54 | 37 | 82 | Resting |
| 5/6/96 | DX 4-A | 32.8 | 58 | Resting |
| 10/19/96 | DX 4-A | 35.9 | 122 | Resting |
| 10/21/96 | EX 59 | 38 | 88 | Resting |
| 11/23/96 | DX 5-A | 41 | 62 | Resting |

D. *Medical Reports*

Mr. Hubbell was hospitalized at Terre Haute Regional Hospital from January 4, 1994 to January 8, 1994, where he was attended by Dr. Robert Avena. (EX 59). The miner presented with a persistent cough, shortness of breath, diarrhea, and generalized weakness. Dr. Avena noted a history of chronic obstructive pulmonary disease and black lung, and a history of smoking an unknown amount before quitting ten years previously. He considered the results of an EKG, a chest x-ray, blood work, and a physical examination. He diagnosed: (1) acute and chronic renal failure; (2) possible sepsis with leukocytosis and bandemia; (3) chronic obstructive pulmonary disease with history of black lung; (4) possible ileus with distended small bowel and colon; and (5) hyponatremia. Dr. Raj Jeevan provided a urological consultation on January 4, 1994, and diagnosed moderately advanced renal insufficiency and possible pneumonitis and underlying chronic obstructive pulmonary disease. Dr. Bharat Dave also consulted on the case on January 8, 1994 and diagnosed renal insufficiency, probably secondary to obstructive uropathy.

The record contains hospital records from Mary Sherman Hospital from May 1994 to October 1996. (DX 4-A). From May 7, 1994 to May 10, 1994, Mr. Hubbell was attended by Dr. Avena, who considered presenting symptoms, a medical history, no known use of tobacco, EKGs, blood work, a pulmonary function study, and the results of a physical examination. Dr. Avena diagnosed: (1) acute exacerbation of chronic obstructive pulmonary disease; (2) hyponatremia; (3) hypertension; (4) backache; (5) coronary heart disease with history of old myocardial infarction; and (6) tachycardia.

From June 24, 1994 to June 28, 1994, the miner was hospitalized and attended by Dr. Avena. (DX 4-A; EX 58). He examined Mr. Hubbell and considered a blood gas study, an x-ray, and symptomatology. Dr. Avena diagnosed: (1) pneumonia; (2) chronic obstructive pulmonary disease with acute exacerbation; (3) electrolyte fluid disturbance; (4) black lung disease; and (5) hypertension.

Dr. Anand Bhuptani examined the miner on August 1, 1994, at the behest of Dr. Avena. (EX 53). He considered symptoms, a history of smoking one pack of cigarettes a day for 30 years before stopping 12 years previously, 43 years of coal mine employment at a strip mine as a parts man and mechanic, and a medical history. Dr. Bhuptani also reviewed the results of an x-ray and a physical examination, which showed bilateral diffuse and expiratory wheezing. He diagnosed chronic bronchitis and bronchospastic airways disease. He suspected chronic obstructive pulmonary disease and noted a history of coal dust exposure. Dr. Bhuptani is Board-certified in internal medicine and pulmonary disease.

From October 18, 1994 to October 22, 1994, Dr. Avena again attended Mr. Hubbell at Mary Sherman Hospital. (DX 4-A). He considered the miner's medical history, current symptoms, blood work, a blood gas study, and the results of a physical examination. Dr. Avena diagnosed: (1) pneumonia; (2) chronic obstructive pulmonary disease; (3) black lung disease; (4) abdominal aortic aneurysm; (5) gastroesophageal reflux disease; and (6) osteoarthritis.

Dr. Avena followed Mr. Hubbell during a hospitalization beginning August 6, 1995 for severe low back pain. (EX 59). Mr. Hubbell provided a history of having quit smoking in 1982. Dr. Avena took a medical history, noted complaints, and examined the miner. He diagnosed: (1) acute low back pain; (2) history of compression fractures over the thoracolumbar vertebra; (3) osteoporosis; (4) chronic obstructive pulmonary disease; (5) hypertension; (6) post herpetic neuralgia; and (7) anxiety and depression.

Dr. Roberto Cantillo's progress notes from August 23, 1995 to December 11, 1995 are of record. (EX 55). He examined Mr. Hubbell on several occasions during hospitalizations, noting decreased breath sounds. He followed the miner for chronic back pain and chronic obstructive pulmonary disease.

From May 5, 1996 to May 6, 1996, Dr. Avena attended Mr. Hubbell at Mary Sherman Hospital. (DX 4-A). After considering presenting symptoms, a blood gas study, and a physical examination, he diagnosed: (1) acute exacerbation of chronic obstructive pulmonary disease; (2) acute bronchitis; (3) hypertension; (4) osteoporosis; and (5) osteoarthritis.

Another report of a hospitalization from June 8, 1996 to June 10, 1996 shows that Dr. Avena diagnosed: (1) reflux esophagitis; (2) electrolyte fluid disorder; (3) chronic airway obstruction; and (4) diaphragmatic hernia. (EX 58).

Mr. Hubbell was hospitalized from October 15, 1996 to October 20, 1996, under the care of Dr. Avena. (DX 4-A; EX 57). After considering an x-ray, a CT scan, symptoms, and a physical examination, Dr. Avena diagnosed: (1) acute exacerbation of chronic obstructive pulmonary disease; (2) coal workers' pneumoconiosis; (3) pulmonary collapse; (4) esophageal reflux disease; (5) hypertension; (6) anemia; and (7) malignant neoplasm of the left bronchus. Dr. Maria B. Antonio-Miranda consulted on October 18, 1996. (EX 58). She performed a physical examination, noting in her report a history of black lung and chronic obstructive pulmonary disease, a history of smoking one pack of cigarettes per day for about 35 years before quitting almost 15 years previously, 43 years of coal mine employment, symptoms, and the results of a chest x-

ray and CT scan. She felt the miner probably had bronchogenic cancer. Dr. B. Jailawala evaluated Mr. Hubbell's radiation therapy for lung cancer on October 20, 1996. (EX 59).

The record contains hospital records from Terre Haute Regional Hospital from October 20, 1996 to December 2, 1996. (DX 5-A). They reveal that the miner was hospitalized from October 20, 1996 to November 1, 1996, and again from November 4, 1996 to November 20, 1996, when he was attended by Dr. Robert Avena. During this time, Dr. Enrico Garcia performed a small bowel endoscopy. Dr. Avena considered the miner's medical history, a history of having smoked one pack of cigarettes a day for 35 years but having quit several years ago, a physical examination, and blood work. Dr. Avena diagnosed: (1) chronic obstructive pulmonary disease with acute exacerbation; (2) malignant neoplasm of the bronchus/lung; (3) diaphragmatic hernia; (4) reflux esophagitis; (5) coal workers' pneumoconiosis; (6) hypertension; (7) protein-calorie malnutrition; (8) acute post-hemorrhagic anemia; (9) hyposmolality; (10) neoplastic anemias; (11) agranulocytosis; (12) anxiety; (13) backache; and (14) brief depressive reaction. Dr. Cantillo again consulted on the miner's case and diagnosed non-small cell carcinoma of the lung. (EX 59).

The miner was seen by Dr. Avena at Terre Haute Regional Hospital on November 4, 1996. (EX 59). The miner presented with a cough and hemoptysis. After considering the miner's symptoms, medical history, a habit of smoking a pack of cigarettes a day for 35 years before quitting several years ago, and the results of a physical examination, the physician diagnosed: (1) hemoptysis; (2) back pain; (3) bronchogenic carcinoma; (4) chronic obstructive pulmonary disease with black lung; (5) anxiety disorder; (6) depression; (7) osteoarthritis; and (8) gastroesophageal reflux disease.

Mr. Hubbell was also admitted to the hospital at the end of November 1996 and remained until December 2, 1996, when he was attended by Dr. Avena. (DX 5-A). The physician considered the miner's presenting symptoms, medical history, a chest x-ray, blood work, and the results of a physical examination. He made the final diagnoses of: (1) malignant neoplasm of the bronchus; (2) chronic obstructive pulmonary disease with acute exacerbation; (3) protein calorie malnutrition; (4) acute post-hemorrhagic anemia; (5) bacterial pneumonia; (6) fluid overload disorder; (7) paroxysmal atrial tachycardia; and (8) coal miner's pneumoconiosis.

Mr. Hubbell was re-admitted on December 2, 1996 and remained in the hospital until his death on December 17, 1996. (EX 57). Hospital notes show that the final diagnoses were bronchogenic carcinoma, black lung, and chronic obstructive

pulmonary disease. Listed by Dr. Avena as the causes of death were respiratory arrest secondary to bronchogenic carcinoma, black lung and chronic obstructive pulmonary disease.

Ray Hubbell died on December 17, 1996. (DX 3-A). The death certificate is signed by Dr. Frederick R. Ridge. He listed the causes of death as bronchogenic carcinoma and black lung.

Dr. Sarah B. Long provided a short medical opinion at the request of the Department of Labor, dated August 12, 1997. (DX 6-A). She was asked to review attached medical evidence, which is not set out in the record, to determine whether Mr. Hubbell's death was due to pneumoconiosis. She relied on 43 years of coal mine employment and the establishment of pneumoconiosis and responded that death was due to carcinoma of the lung. She added that the underlying pneumoconiosis would have been a contributing factor in the death which was due to respiratory impairments including coal workers' pneumoconiosis.

Dr. Peter G. Tuteur, who is Board-certified in internal medicine and pulmonary disease, conducted an independent medical review of the evidence on August 10, 1998. (EX 62). He considered all the evidence he had previously reviewed both on May 13, 1994 and October 3, 1994, as well as a CT scan report from October 17, 1996, medical records and reports from Drs. Cantillo, Bhuptani, Long, Jailwala, and Avena, the death certificate, hospital records from Terre Haute Regional Hospital and Mary Sherman Hospital, 18 blood gas studies, 32 x-ray reports, and the May and August 1994 pulmonary function studies. Based on all the medical data, Dr. Tuteur opined:

Mr. Ray Hubbell did not have clinically significant, physiologically significant, or radiographically significant coal workers' pneumoconiosis or any other coal mine dust-induced disease process. During life, he did have a primary pulmonary process. That process is cigarette smoke-induced chronic bronchitis associated with a progressive airways obstruction. Eventually a second primary pulmonary process, carcinoma of the lung was diagnosed and was directly responsible for his death. Other health problems including advanced non-ischemic cardiomyopathy, eventually controlled hypertension, obstructive uropathy, low back syndrome, peptic ulcer disease with exacerbations, cholecystitis requiring cholecystectomy, and additional musculoskeletal problems involving the right knee are all conditions not related to, not aggravated by and not caused by either the inhalation of coal mine

dust or the development of coal workers' pneumoconiosis.

Dr. Tuteur also opined that Mr. Hubbell died because of metastatic carcinoma of the lung.

Dr. Steven M. Koenig, who is Board-certified in internal medicine, critical care medicine, and pulmonary disease, reviewed medical data on March 1, 2000. (CX 22). He considered 41 years of coal mine employment, including the miner's jobs and their exertional requirements. He also reviewed a medical history, symptoms, and a history of smoking one to one and one-half packs of cigarettes a day for 40 to 46 years before quitting somewhere between 1980 and 1986. He considered the seven pulmonary function studies between 1981 and 1994, as well as 23 blood gas studies between 1981 and 1996, a November 1996 EKG, chest x-rays, hospital records, and the report of Dr. Tuteur. Dr. Koenig opined that Mr. Hubbell's dust exposure was sufficient to cause respiratory impairment in a susceptible individual, and the miner had no other occupational exposure which could account for his impairment. He found that Mr. Hubbell had a totally disabling pulmonary impairment due to obstructive lung disease, which included chronic bronchitis and emphysema. He feels that cigarette smoking may have contributed to the miner's chronic obstructive pulmonary disease and consequent respiratory impairment and total disability. Dr. Koenig also averred that even if the miner had never smoked and had no evidence of pneumoconiosis on x-ray and pulmonary function testing, his coal dust exposure alone could have caused or at least significantly contributed to his chronic obstructive pulmonary disease and resultant total disability. He pointed out that attributing the miner's respirator disability only to cigarette smoking disregards many valid studies in the medical literature and experts in occupational lung disease. Lastly, Dr. Koenig opined that the cause of death was respiratory arrest contributed to by severe underlying chronic obstructive pulmonary disease and the effect of lung cancer. According to that physician, without the severe chronic obstructive pulmonary disease, Mr. Hubbell would not have died as quickly. Therefore, Dr. Koenig reasoned, coal dust exposure could have significantly contributed to and hastened Mr. Hubbell's death.

II. Discussion

A. *The Miner's Claim*

Modification and Associated Issues

Mr. Hubbell's request for modification was filed within one year of the July 1997 denial of the 1992 duplicate claim.

Section 725.310(a) permits modification of a denial of a claim by proving either that the claimant's condition has changed or that a mistake in fact was made in denying the previous claim. Thus, the medical evidence concerning both Mr. Hubbell's earlier claims and his motion for modification must be considered. Also, the evidence must be analyzed under Part 718 because both the claim and his motions for modification were filed after March 31, 1980.

In order to be entitled to benefits, the claimant must establish that he has pneumoconiosis, that he is totally disabled as a result of that disease and that the pneumoconiosis arose out of coal mine employment. In the prior decisions, it was found that Mr. Hubbell had pneumoconiosis arising out of coal mine employment and that he was totally disabled from a respiratory standpoint. However, it was also found that his total disability was not due to pneumoconiosis under the Seventh Circuit standard. Thus, to establish entitlement with respect to the claimant's petition for modification, he must prove that his condition has changed since the last decision or that a mistake in fact was made in denying that claim.

Section 718.202 provides the methods by which a claimant may establish the existence of pneumoconiosis under this part of the regulations. Under Section 718.202(a)(1), a chest x-ray conducted and classified in accordance with Section 718.102 may form the basis for a finding of the existence of pneumoconiosis.

Since the prior denial, the record contains 21 readings of as many separate x-rays. Although none of these x-rays was specifically interpreted as evincing pneumoconiosis, I note that they were all taken during hospitalizations and, thus, were not necessarily read for the presence or absence of pneumoconiosis. Having thoroughly reviewed all the prior x-ray evidence, and the prior judge's consideration of same, I concur that the preponderance of the x-ray evidence tends to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(1). I also find that the 21 newly submitted x-rays bolster that finding. There are many readings of chronic obstructive pulmonary disease, and, according to Section 718.201, chronic obstructive pulmonary disease comes within the ambit of legal pneumoconiosis if it is found to be related to coal mine employment.

A biopsy conducted and reported in compliance with Section 718.106 may also be the basis for a finding of the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2). However, there is no biopsy evidence in the record to consider.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305 or 718.306 are applicable. Since there is no x-ray evidence of complicated pneumoconiosis in the record, Section 718.304 does not apply. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant since it is to be used in connection with the claims of deceased miners who died on or before March 1, 1978.

Section 718.202(a)(4) provides that a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based on objective medical evidence, and shall be supported by a reasoned medical opinion.

The newly submitted evidence contains opinions relevant to this inquiry from Drs. Avena, Bhuptani, Cantillo, Ridge, Tuteur, and Koenig. Dr. Avena diagnosed pneumoconiosis. Dr. Ridge listed black lung as a cause of death. Dr. Bhuptani suspected chronic obstructive pulmonary disease. Dr. Cantillo diagnosed chronic obstructive pulmonary disease. Dr. Koenig found that the miner's coal dust exposure could have caused his chronic obstructive pulmonary disease. Dr. Tuteur did not find pneumoconiosis.

As with the x-ray evidence, I have reviewed all the prior medical opinions of record and the prior administrative law judge's consideration of them. I agree with that judge's reasoning and find that those medical opinions tend to establish, by a preponderance of the evidence, the existence of pneumoconiosis. Regarding the newly submitted evidence, I place the greatest weight on Dr. Avena's opinion because he treated Mr. Hubbell from January 1994 to the time of his death in December 1996. During those three years, Dr. Avena attended the miner during myriad hospitalizations and had the unique opportunity to become familiar with his health and deteriorating condition in all respects. *Schaaf v. Matthews*, 574 F.2d 157, 160 (3rd Cir. 1978); *Gomola v. Manor Mining and Contracting Corp.*, 2 BLR 1-130, 1-135 (1979). Dr. Avena considered several chest x-rays, was well aware of Mr. Hubbell's smoking and coal mine employment histories, and examined the miner on numerous occasions. Thus, I consider his opinion extremely well-documented and reasoned. *Perry*, 9 BLR 1-1 (1986).

I place some weight on Dr. Bhuptani's opinion because it is well-documented and reasoned, and his credentials illustrate his expertise in pulmonary disease. *Id.*; *Wetzel v.*

Director, OWCP, 8 BLR 1-139 (1985). However, Dr. Bhuptani failed to ascribe an etiology to the miner's chronic bronchitis and suspected chronic obstructive pulmonary disease, although he noted a history of coal dust exposure, hinting that he may have felt there was a causal nexus between that exposure and his diagnoses. However, because of the doctor's failure to provide a cause for the diagnosed conditions, I find that his report neither supports nor contradicts a finding of pneumoconiosis.

I place no weight on Dr. Cantillo's opinion because he primarily treated the miner for his cancer. Moreover, his progress notes are insufficient to establish whether he was aware of the miner's smoking and coal mine employment histories. Without such knowledge, his opinion is not well-documented or reasoned. *Minton v. Director, OWCP*, 6 BLR 1-670 (1983). I place no weight on Dr. Ridge's inclusion of black lung on the death certificate. Dr. Ridge's name does not appear elsewhere in the record, and therefore there is no evidence that he ever examined Mr. Hubbell or was familiar with his condition, smoking history, employment history, or medical data.

I discount Dr. Tuteur's opinion for the same reasoning provided by the prior administrative law judge. He relied heavily upon the negative x-ray readings, whereas I have found that the x-ray evidence establishes pneumoconiosis.

I also discount Dr. Koenig's opinion as equivocal. *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). He couched his opinion regarding the etiology of the chronic obstructive pulmonary disease in terms of "could have." These indefinite verbs evince an opinion stated in terms that do not constitute reasoned medical probability. Nonetheless, I find that the medical opinion evidence tends to establish, by a preponderance of the evidence, the existence of pneumoconiosis. I further find that consideration of all the evidence under Section 718.202(a) establishes the existence of pneumoconiosis. See *Island Creek Coal Co. v. Compton*, ___ F.3d ___, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3rd Cir. 1997).

It must also be determined whether the pneumoconiosis which Mr. Hubbell suffered was caused at least in part by his coal mine employment. In this case, however, that relationship may be presumed because it has been established that the claimant worked at least ten years as a coal miner. 20 C.F.R. § 718.203(b). Moreover, the weight of the medical evidence fails to establish any cause for the miner's pneumoconiosis other than coal mine employment. Thus, the presumption is not rebutted.

After the claimant has established pneumoconiosis arising from coal mine employment, he must still establish that he has been totally disabled by the disease. A claimant is considered totally disabled when he is no longer able to perform his usual coal mine work. 20 C.F.R. § 718.204(b)(2). Section 718.204 provides several criteria for determining that a claimant is totally disabled.

Subsection (c)(1) of Section 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV₁ values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC values or MVV values equal to or less than the applicable table values. Alternatively, a qualifying² FEV₁ reading together with an FEV₁/FVC ratio of 55% or less may be sufficient to prove a totally disabling respiratory impairment under this subsection of the regulations.

In the prior decisions, it was found that the claimant had established total disability pursuant to Section 718.204(c)(1) by a preponderance of the evidence. There is one additional pulmonary function study since the last denial. It produced qualifying values prior to the administration of a bronchodilator, but not after. However, the test administrator noted some difficulty on the miner's part when he initiated the study, and found Mr. Hubbell's comprehension questionable. Dr. Tuteur found the study did not illustrate the miner's maximum function, and Dr. Renn invalidated the study for a number of reasons. Consequently, I do not consider this study valid. Nevertheless, having thoroughly reviewed all the prior studies in connection with the August 18, 1994 study, I agree with the reasoning of the prior administrative law judge and still find the weight of this evidence establishes total disability under this subsection.

Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO₂ to pO₂, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the claimant's lung alveoli to his blood. 20 C.F.R. § 718.204(c)(2) and Appendix C.

The blood gas study evidence submitted in connection with the prior claims failed to establish total disability. Since the most recent denial, there have been 24 additional tests

²A "qualifying" pulmonary function study or arterial blood gas study yields values which are equal to or less than the applicable table values, i.e., Appendices B and C of Part 718. See 20 C.F.R. § 718.204(c)(1) and (c)(2). A "non-qualifying" test produces results which exceed the requisite table values.

submitted with the request for modification. Of these, seven produced qualifying values. I note, however, that these were taken during the miner's myriad hospitalizations, when he suffered from conditions such as pneumonia and lung cancer. The three most recent studies, all taken within two months of the miner's death, failed to establish total disability. Accordingly, I find that the claimant has failed to prove total disability pursuant to Section 718.204(c)(2).

A miner shall be considered totally disabled under Section 718.204(c)(3) where he suffers from pneumoconiosis and has been shown by medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure. There is no such evidence in this case.

Where total disability cannot be established under subparagraphs (c)(1), (c)(2) or (c)(3), Section 718.204(c)(4) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

In the prior decisions, the administrative law judge found that the miner established total disability pursuant to Section 718.204(c)(4). I agree with his reasoning and find no mistake in it. Of the evidence submitted since that denial, the sole opinion bearing on this issue comes from Dr. Koenig. He opined that the miner had a totally disabling respiratory impairment. I place great weight on this opinion because it is supported by the underlying objective data; it is well-reasoned and documented. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Dr. Koenig had a broad base from which to draw his conclusions, and he is an expert in the field of pulmonary disease. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). Consequently, I conclude that the claimant has established total disability pursuant to Section 718.204(c)(4).

The Seventh Circuit, which has appellate jurisdiction in this case, holds that pneumoconiosis must be a "simple contributing cause" of the miner's total disability. That is, pneumoconiosis must be a necessary, but need not be a sufficient, cause of the miner's total disability. *Hawkins v. Director, OWCP*, 907 F.2d 697, 707 (7th Cir. 1990); *Shelton v. Director, OWCP*, 899 F.2d 690, 693 (7th Cir. 1990). Consequently, if a miner's pulmonary disability has multiple causes, he is not entitled to benefits "if he would have been unable to work even had he never been exposed to coal dust."

Freeman v. United Coal Mining Co., 30 F.3d 834, 838 (7th Cir. 1994).

In the most recent denial, the administrative law judge set forth that Drs. Cook and Tuteur, relying on the obstructive impairment shown on spirometry, felt Mr. Hubbell's respiratory impairment was caused entirely by cigarette smoking and not by conditions unrelated to coal dust exposure. On the other hand, Drs. Lenyo and Combs found the miner's pneumoconiosis totally disabling, but I find that they failed to fully explain their reasons for so finding. The prior administrative law judge credited the opinions of Drs. Cook and Tuteur over those of Drs. Lenyo and Combs, and thus concluded that Mr. Hubbell failed to establish that the claimant's coal dust related impairment was totally disabling. The judge also concluded that the opinions failed to establish that Mr. Hubbell's mining was a necessary condition of his disability. I have carefully reviewed this medical evidence and agree with the prior judge's determinations.

The newly submitted evidence bearing on this issue comes from Drs. Tuteur and Koenig. Dr. Tuteur reaffirmed his prior opinion that Mr. Hubbell's primary pulmonary process was cigarette smoke-induced chronic bronchitis associated with a progressive airways obstruction, followed by a second pulmonary process of carcinoma of the lung. He also listed other health problems, including cardiomyopathy and hypertension, which were not caused by coal mine dust inhalation.

Dr. Koenig stated that the miner's dust exposure was sufficient to cause respiratory impairment in a susceptible host and found no other occupational exposure which could account for the impairment. He found a totally disabling pulmonary impairment due to chronic obstructive pulmonary disease, including chronic bronchitis and emphysema, and felt that cigarette smoking may have contributed to the chronic obstructive pulmonary disease and consequent disability. Dr. Koenig added that Mr. Hubbell's coal dust exposure alone could have caused or at least significantly contributed to his chronic obstructive pulmonary disease and resultant total disability.

I find Dr. Koenig's opinion too obliquely stated to support a finding in the miner's favor. He averred that Mr. Hubbell's dust exposure was sufficient to cause respiratory impairment in a susceptible person but did not specify that Mr. Hubbell was a susceptible host. While he ruled out other occupational exposure as a cause of the miner's disability, he did not rule out cigarette smoking-induced conditions as causes. In fact, he admitted that cigarette smoking may have

contributed to the chronic obstructive pulmonary disease and consequent disability.

Dr. Koenig again averred, in equivocal terms, that Mr. Hubbell's coal dust exposure alone *could have caused* or at least significantly contributed to his chronic obstructive pulmonary disease and resultant total disability. This indefinite causal nexus fails to rise to the standard of a reasoned medical opinion. See *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Dr. Koenig also failed to address other causes of the miner's disability such as cardiomyopathy. Consequently, I do not place much weight on Dr. Koenig's opinion.

I conclude that the newly submitted evidence, when considered together with all the prior medical evidence, fails to establish that Mr. Hubbell's coal dust-related impairment was totally disabling or that his coal mine employment was a necessary condition of his disability. Stated otherwise, the evidence fails to prove that the miner's pneumoconiosis was a contributing cause of his total disability. Thus, the most recent claim of Mr. Hubbell, as well as Mrs. Hubbell's request for modification, must be denied.

B. *The Widow's Claim*

Mrs. Hubbell must prove that pneumoconiosis caused the miner's death. Section 718.205(c) provides that with respect to survivors' claims filed after January 1, 1982, death will be considered due to pneumoconiosis if any one of the following criteria are met:

(1) where competent medical evidence establishes the miner's death was due to pneumoconiosis; or,

(2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis; or,

(3) where the presumption set forth in Section 718.304 is applicable.

Initially, I note that the presumption at Section 718.304 is not applicable to this claim because there is no evidence of complicated pneumoconiosis. Therefore, death due to pneumoconiosis is not established by this method. 20 C.F.R. § 718.205 (c)(3).

Section 718.205(c)(2) presents a liberal standard for proving "death due to pneumoconiosis." Moreover, some of the circuits which have considered that standard have accepted the interpretation of the Director "that the words 'substantially contributing cause or factor leading to the miner's death' . .

. means anything that has 'an actual or real share in producing an effect' and that any condition which hastens death fits this description." *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1004 (3d Cir. 1989); see also *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992).

The evidence impacting upon this issue is the death certificate and the opinions of Drs. Avena, Long, Tuteur, and Koenig. The death certificate lists black lung, along with bronchogenic carcinoma, as the causes of death. Dr. Avena listed black lung as a cause of death after Mr. Hubbell's final hospitalization. Dr. Long asserted that the miner's underlying pneumoconiosis would have been a contributing factor in his death, which was due to respiratory impairments. Dr. Koenig averred that coal dust exposure could have significantly contributed to and hastened the miner's death, which was caused by respiratory arrest contributed to by severe underlying chronic obstructive pulmonary disease and the effects of lung cancer. He believed that without the severe chronic obstructive pulmonary disease, the miner would not have died as quickly. To the contrary, Dr. Tuteur found that death was due to metastatic carcinoma of the lung. He, of course, did not diagnose pneumoconiosis.

I place no particular weight on the death certificate because there is no prior indication that Dr. Ridge ever treated Mr. Hubbell or was aware of his condition. Furthermore, his credentials are not of record.

I place great weight on Dr. Avena's opinion for the reasons mentioned above. He treated Mr. Hubbell for the last three years of his life, attending him during numerous hospitalizations. He was extremely familiar with the miner's medical condition. *Schaaf*, 574 F.2d at 157.

I place little weight on Dr. Long's opinion because it cannot be gleaned from the record which evidence she reviewed in reaching her conclusion. I do, however, find that it supports Dr. Avena's conclusion.

Dr. Koenig's opinion is once again too equivocal to merit much weight. He never specifically diagnosed pneumoconiosis. Although he attributed death to respiratory arrest contributed to by chronic obstructive pulmonary disease and lung cancer, the closest he comes to linking the chronic obstructive pulmonary disease to coal mine employment is to state that "coal dust exposure *could* have significantly contributed to and hastened" the miner's death. Once again, I find his reliance on the indefinite helping verbs, "could have," fails to render

his opinion well-reasoned. It is certainly not stated in terms of reasoned medical probability.

Dr. Tuteur opined that death was directly due to carcinoma of the lung, the second primary pulmonary process from which Mr. Hubbell suffered. Dr. Tuteur did not address whether pneumoconiosis played any role in hastening the miner's death, most likely because he did not diagnose the disease. While I place great weight on Dr. Tuteur's opinion that lung cancer was a cause of death, based on his thorough review of the medical evidence and his credentials, I also find that his failure to consider the existence of pneumoconiosis, which I have found existed, detracts from the probity of his conclusion. While other physicians addressed the contribution of respiratory conditions other than the cancer to Mr. Hubbell's death, Dr. Tuteur's opinion is silent on the matter.

Consequently, I am persuaded by the opinion of Dr. Avena, as bolstered by the findings of Drs. Long and Ridge, that pneumoconiosis at least hastened Mr. Hubbell's death. This opinion is further supported by the miner's 43 years of coal mine employment which exposed him to significant coal dust, and his documented respiratory disability. Therefore, I find Mrs. Hubbell is entitled to survivor's benefits.

Date of Entitlement

The onset date for the payment of black lung benefits in the case of a survivor's claim is the month of the miner's death. 20 C.F.R. § 725.503(c). Because Mr. Hubbell died in December 1996, Mrs. Hubbell's benefits will commence as of December 1, 1996.

Attorney's Fee

Forty-five days are allowed to Mrs. Hubbell's counsel for the submission of an application for an attorney's fee. The application shall be prepared in strict accordance with 20 C.F.R. §§ 725.365 and 725.366. The application must be served on all parties, including the claimant, and proof of service must be filed with the application. The parties are allowed thirty days following service of the application to file objections to the application for an attorney's fee. In the event this decision is appealed, claimant's counsel can elect to withhold the filing of his fee petition pending the appeal.

ORDER

IT IS HEREBY ORDERED that the claim of Ray Hubbell for benefits under the Act is denied. However, because Iva

Hubbell has been found entitled to benefits, the employer, Peabody Coal Company, IS HEREBY ORDERED:

1. to pay to Mrs. Hubbell, all benefits, to which she is entitled under the Act, commencing December 1, 1996;

2. to pay to the Secretary of labor, reimbursement for any payment the Secretary has made to the claimant under the Act and to reduce such amounts, as appropriate, from the amounts the employer is ordered to pay under paragraph 1 above; and,

3. to pay to the Secretary of Labor, or to the claimant, as appropriate, interest computed in accordance with the provisions of the Act or regulations.

DONALD W. MOSSER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a notice of appeal with the Benefits Review Board, 800 K Street, NW, Suite 500, Washington, D.C. 20001-8001. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, D.C. 20210.